

BEFORE THE  
MEDICAL BOARD OF CALIFORNIA  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

FELIX LOUIS NEGRON, M.D.,

Physician's and Surgeon's Certificate  
No. A26513,

Respondent.

Case No. 800-2016-020748

OAH No. 2016090691

**DECISION AFTER NON-ADOPTION**

Administrative Law Judge Carla L. Garrett heard this matter on February 6 and 7, 2017, at Los Angeles, California.

Cindy M. Lopez, Deputy Attorney General, represented Complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California (Board). James T. Studer, Attorney at Law, represented Felix Louis Negron, M.D. (Respondent), who was present at hearing.

Oral and documentary evidence was received, the record was closed, and the matter was submitted for decision on February 7, 2017. Panel B of the Board declined to adopt the proposed decision and on May 8, 2017, issued an Order of Non-Adoption. On July 26, 2016, at a noticed meeting, Panel B heard oral argument from Respondent's counsel and the Office of the Attorney General, and written argument was submitted by both. Panel B, having heard the oral argument and having considered the written arguments and read and reviewed the entire administrative record, hereby makes and enters the following as its decision in the above-captioned matter.

**FINDINGS OF FACT**

1. Complainant made the Accusation in her official capacity as Executive Director of the Board.
2. The Board issued Physician's and Surgeon's Certificate Number A26513 to Respondent on February 11, 1975. The certificate expired on November 30, 2016 and is in a delinquent status.

### *Preliminary Background Information*

3. In a disciplinary action entitled *In the Matter of the Accusation Against Felix Louis Negron, M.D.*, Case No. 05-2011-217285, Complainant alleged Respondent engaged in gross negligence and repeated acts of negligence in the care and treatment of a patient. Specifically, Complainant alleged Respondent treated a patient with antibiotics without an established clinical basis upon which to justify such an action. Additionally, Complainant alleged Respondent destroyed all of the patient's records.

4. The Board, pursuant to a stipulated settlement reached between Complainant and Respondent, issued a decision effective November 14, 2014 that publically reprimanded Respondent's certificate, subject to terms and conditions. Those conditions included a requirement that Respondent successfully complete the Medical Record-Keeping course and the Physician Assessment and Clinical Education (PACE) program at the University of California at San Diego (UCSD).

### *PACE Program Background*

5. Dr. William Norcross, who has been a board certified physician in family medicine since 1977, is the founder of PACE. Dr. Norcross testified at hearing. Dr. Norcross earned his bachelor's degree in chemistry from Ursinus College in 1970, and his doctor of medicine from Duke University School of Medicine in 1974. Dr. Norcross completed his residency at UCSD in 1977. Dr. Norcross, in addition to being the director at PACE, has been a clinical professor of family medicine at UCSD School of Medicine since 2007. He has served in a number of other academic positions, and has been the recipient of a number of awards, including San Diego Magazine's Best Doctors award for consecutive years between 2004 and 2015, and Physician of the Year at UCSD Medical Center. Dr. Norcross has given a number of presentations and lectures, and has authored a number of published letters and book chapters.

6. Dr. Norcross founded PACE in 1986. PACE is a program for the assessment of physician competence, the detection of problems or deficiencies, and, when possible, the remediation of those problems or deficiencies. There are six core domains of competence: (1) patient care; (2) medical knowledge; (3) practice-based learning and improvement; (4) communication; (5) professionalism; and (6) systems-based practice. All six competencies are evaluated during a physician's participation in PACE.

7. PACE is comprised of two phases. Phase 1 consists of multi-day testing in which physicians are required to do the following: (1) provide self-reporting measures; (2) perform a mock patient history and physical; (3) undergo a physical examination and mental health screening; (4) take a cognitive screening test; (5) undergo an oral clinical examination; (6) submit to a charts review; (7) take computer-delivered tests; (8) undergo a transaction stimulated recall interview; (9) take multiple choice exams; (10) take an ethics and communication examination; (11) take a mechanisms of disease exam; (12) take a family medicine clinical science subject exam; and (13) participate in an exit interview.

8. Phase 2 consists of multi-day testing that requires physicians to: (1) complete a standardized patient evaluation; (2) undergo a chart stimulated recall examination; (3) perform in multi-day clinical sessions; (4) complete an evidence-based medicine project; and (5) undergo a Pulse 360 Degree Workplace Assessment.<sup>1</sup>

9. If a physician exhibits neurological issues, PACE makes a determination whether the physician must undergo neurological testing. Approximately 25 percent of physicians attending PACE are referred out neurological examinations.

10. A PACE committee of nine physicians and case managers reviews all of the results yielded from the Phase 1 and Phase 2 testing, and makes a determination whether a physician has passed or failed PACE. All committee members must be in full agreement. Approximately 87 percent of physicians pass PACE.

#### *PACE Phase 1*

11. Respondent participated in Phase 1 of PACE from February 3 through 4, 2015. During the mock patient history and physical examination, Respondent rushed through both the history and physical exam, seemed impatient when it came to listening to the patient, demonstrated a limited review of systems, and failed to ask any follow up questions. He asked very little about the patient's social history, but commented twice to the patient that she had beautiful hair. Overall, Respondent's performance of the history and physical was not deemed to be within the standard of care.

12. Dr. Sheila Pickwell, a clinical professor of family medicine and public health, performed a physical examination of Respondent, and other than an elevated blood pressure reading, found no health concerns or physical abnormalities. Although Dr. Pickwell and Respondent did not know each other, Respondent patted Dr. Pickwell on her stomach before the exam began, and touched her arm several times during the exam. At hearing, Respondent explained that he touched Dr. Pickwell's stomach as a result of role-playing in which Dr. Pickwell played a patient who had just undergone surgery, and Respondent touched her stomach during the mock examination.

13. Respondent completed a cognitive screening test using Microcog, which is a computer-based assessment of cognitive skills used to determine which PACE participants should be referred for a full neuropsychological evaluation. The test required some proficiency with computers; however, a proctor was available to answer questions about test instructions. With respect to Respondent, relative to a person of similar age and educational background, he performed in the low average range in the areas of general cognitive functioning, general cognitive proficiency, information processing speed, attention and mental control, reasoning and calculation, and spatial processing. He scored in the average range in the areas of information processing accuracy, memory, and reaction time. However, when compared to the general population,

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<sup>1</sup> PULSE 360 Degree is a survey system designed to show healthcare professionals how they are viewed on core competencies.

Respondent scored in the below average range in all areas except for memory and reaction time, which he scored in the low average range.

14. Dr. Martin Schulman performed a one-hour oral examination on Respondent, in which Respondent was given six separate scenarios of patient issues, and asked to take histories of the patients, provide initial differential diagnosis of each patient's ailment(s), and propose a treatment plan. Respondent scored in the average range on all six scenarios, but Dr. Schulman noted Respondent tended to take incomplete histories of the patients, and, in a few of the scenarios, demonstrated a need for updating his approach to problem management.

15. Dr. Schulman also conducted a chart review of seven chart entries from Respondent. The global overall assessment showed that Respondent scored in the "meets standards" range for three charts, in the "caution/borderline" range for two charts, and in the "do not meet standards" range for two charts.

16. Respondent completed PRIMUM, which were computer-delivered tests to assess his knowledge of clinical decision-making and patient-management skills. PRIMUM consisted of a mix of eight urgent and non-urgent cases that Respondent was required to manage. Computer literacy was a factor on this exam, and, at hearing, Respondent testified he was not familiar with this type of testing and how to respond on the computer. However, Respondent had the opportunity to practice at home before coming to the assessment and to complete five practice cases before starting the actual exam. If requested, a proctor was also available to serve as a scribe on the keyboard or answer questions about how to maneuver around within the computer program. Respondent scored in the first or lowest quintile in all eight cases.

17. At the completion of the PRIMUM computer case simulations, Dr. Schulman interviewed Respondent to gain a better understanding of his performance. Respondent advised Dr. Schulman that his computer skills were at "about a 2 or 3 on a scale of 1 to 10," but Respondent never requested a proctor to type his responses for him. Out of the eight diagnoses, Respondent got three of them correct. Dr. Schulman noted Respondent demonstrated some deficiencies in his medical knowledge and clinical judgment, with an overall unsatisfactory performance. Dr. Schulman also noted that Respondent demonstrated some memory difficulties.

18. Respondent completed a 100-item multiple-choice test to assess medical knowledge and knowledge of ethics and communication. Respondent scored 59 percent on this exam, which was in the first percentile of the 2,000 physicians in the reference group who took the United States Medical Licensing Examination (USMLE) for the first time and who had completed one to three years of residency training.

19. Respondent completed a 120-item multiple-choice test that assessed applied basic science principles underlying medicine. Many of the questions were related to manifestations and symptoms of disease, particularly in the areas of behavioral science, anatomic structure, pathology and laboratory medicine, infectious disease and immunology, pathophysiology, and physiology and metabolism. Respondent scored 47 percent on this exam, which was in the first percentile of the 2,000 physicians in the reference group who took the USMLE for the first time and who had

completed one to three years of residency training.

20. Respondent completed a family medicine clinical science subject exam, designed to assess overall broad knowledge in the field of family medicine. Respondent's overall score was in the first percentile when compared to a reference group of 6,000 first-time takers from more than 55 schools who took the exam as their final clerkship examination.

21. Overall, Respondent's performance on the Phase 1 assessment was unsatisfactory. In addition to performing unsatisfactorily on the assessments, Dr. Norcross noted that Respondent also exhibited poor professionalism on several occasions. For example, Respondent patted Dr. Pickwell's stomach, touched her arm several times, and used profanity throughout his assessment and during his exit interview, and commented twice to the mock patient about her hair.

### *Neuropsychological Evaluation*

22. As a result of Respondent's performance on the cognitive screening test, PACE recommended that Respondent undergo a Fitness for Duty Evaluation (FFDE), which is a formal, specialized examination performed by a clinical neuropsychologist that assesses cognitive areas in order to objectively determine where there is evidence that a physician is unable to safely or effectively perform his or her defined duties. The central purpose of an FFDE is not to determine whether the physician meets a certain diagnosis, but rather whether they are able to function effectively as a physician, and in a manner conducive to public safety. PACE refers physicians for a FFDE when there is an objective and reasonable basis for believing that he or she may be unable to safely perform his or her duties due to a neurological/psychological condition or impairment.

23. Dr. William Perry, who is a licensed psychologist that performed Respondent's FFDE neuropsychological evaluation, testified at hearing. Dr. Perry earned his bachelor's degree from Hampshire College in 1979, and his doctorate from the California School of Professional Psychology, with honors, in 1989. Dr. Perry has served as chief psychologist at UCSD since 1998, the executive director at the National Academy of Neuropsychology since 2011, the co-director of the Division of Clinical Psychiatry at UCSD since 2015, and the vice-chair for the Operations and Program Development Department of Psychiatry at UCSD since 2015. He has also served as the professor in residence at UCSD since 2006. Dr. Perry has more than 125 published works.

24. Dr. Perry has conducted more than 1,000 evaluations of physicians associated with the PACE program. Dr. Perry does not administer the tests himself. Rather, Dr. Perry assigns to a post-doctoral fellow the task of administering the tests. Thereafter, Dr. Perry interprets the data.

25. Respondent underwent his neuropsychological evaluation on May 11, 2015. Dr. Perry prepared a written report dated May 23, 2015. Respondent performed adequately on effort measures and appeared to put forth adequate effort throughout neuropsychological testing. With respect to Respondent's general intellectual functioning, Respondent's premorbid level of general intellectual functioning fell within the average range, according to the results of his Test of Premorbid Functioning and Wechsler Abbreviated Scale of Intelligence (2nd Edition).

26. With respect to attention and concentration, which refers to a person's ability to focus for a sustained period of time, as well as mentally manipulate information held in short-term memory, Respondent's performance in this domain was impaired. Specifically, his performance on a task requiring sustained and selective visual attention was impaired, according to the results of his Test of Variables of Attention, and demonstrated significantly high variability in his response time. Respondent's performance on another measure of sustained attention (Digit Vigilance) was in the mildly impaired range in terms of errors and in the mildly to moderately impaired range in terms of time. Additionally, Respondent's working memory index fell within the moderately impaired range, his performance was within the mildly impaired range on a task requiring rote repetition and reversal of numbers, and his performance on a measure of mental arithmetic was in the moderately to severely impaired range.

27. With respect to processing speed and motor functioning, which refers to a person's efficiency in cognitively processing information and producing an output, Respondent's performance in this domain was impaired. His performance on a task requiring visual perception and speed fell within the mildly impaired range. On a task requiring basic sequencing, Respondent scored in the average range. Respondent's fine motor performance with his dominant hand fell within the low average range, while his performance with his non-dominant hand fell within the mildly impaired range.

28. With respect to language, which refers to a person's knowledge of English vocabulary as well as verbal reasoning skills, Respondent's performance in this domain was varied. His verbal abstract reasoning performance fell within the average range, and his performance on a measure of expressive knowledge of vocabulary words fell within the above average range. On a measure of confrontation naming, Respondent's performance fell within the mildly impaired range. Respondent's performance on a measure of letter fluency fell within the average range, while his performance on a measure of semantic fluency fell within the low average range.

29. With respect to visuospatial functioning, which refers to a person's ability to perceive the relationship of objects in space and manipulate them accurately, Respondent's performance in this domain was varied. His performance on spatial problem-solving skills fell within the average range, while his performance on a task of manually constructing designs in a timely fashion fell within the mildly impaired range.

30. With respect to learning and memory, which refers to a person's ability to learn new verbal and non-verbal information, and be able to adequately retrieve the information, store that information, and be able to adequately retrieve the information, Respondent's performance in this domain was impaired. On the California Verbal Learning Test (2nd Edition), Respondent scored within the mildly to moderately impaired range. His "short-delayed" free recall fell within the mildly to moderately impaired range, as did his "long-delayed" free recall performance. Respondent's recognition hits score fell within the severely impaired range, and his overall recognition discriminability score fell within the moderately impaired range. Respondent's total recall on learning and remembering visual materials fell within the moderately to severely impaired range, as was his delayed recall. His recognition discriminability performance fell within the moderately impaired range.

31. With respect to executive functioning, which refers to those cognitive abilities involved in planning, cognitive flexibility, abstract thinking, rule acquisition, initiating appropriate actions and inhibiting inappropriate actions, Respondent's performance in this domain varied. Specifically, on the Category Test, which requires multiple fundamental cognitive skills and higher-level executive functions, Respondent scored within the low average range. On a test requiring speed of information processing and cognitive switching, Respondent's performance fell within the mildly to moderately impaired range. On a measure of cognitive flexibility and novel problem solving, Respondent scored within normal limits.

32. With respect to emotional functioning, Respondent denied symptoms of depression or anxiety on self-report questionnaires of mood symptoms.

33. Dr. Perry concluded that, overall, Respondent's deficits on cognitive testing were of concern and sufficiently deficient that they constituted a concern for his independent practice of medicine. Dr. Perry recommended that Respondent seek a neurological evaluation and consider retesting in six months to determine the stability of the results of this neuropsychological evaluation.

#### *PACE Phase 2*

34. Respondent participated in Phase 2 of PACE from June 22 through 26, 2015. Respondent completed a standardized patient evaluation with Dr. David Bazzo and Dr. Schulman, who assessed Respondent's clinical competence in the areas of interviewing, conducting a physical examination, professionalism, clinical judgment, counseling, and organization. Respondent received an overall clinical competence score that fell within the average range, but Drs. Bazzo and Schulman found his clinical judgment and overall clinical competence scores unsatisfactory in some cases. They concluded Respondent needed to work on his physical examination skills and study ischemic neurological disease.

35. Dr. Bazzo conducted a chart stimulated recall exercise on Respondent, which entailed Dr. Bazzo reviewing 20 chart entries submitted by Respondent for patients examined by Respondent. Dr. Bazzo discussed each of the entries with Respondent, seven of them in great detail. Dr. Bazzo found that, overall, Respondent's documentation needed improvement, as one must be able to recreate from the documentation the essence of the visit. Dr. Bazzo found that Respondent's thought process for the patients appeared intact.

36. Respondent engaged in clinical sessions, in which his performance was rated by PACE faculty with whom Respondent was assigned to shadow. The PACE faculty members addressed the domains of promptness, appearance, participation, professional behavior, communication skills, medical knowledge, and the ability to access evidence-based medicine. Most clinical sessions occurred in the morning and afternoon on five consecutive days. On Day One, Dr. Patricia Brady gave Respondent a rating of superior in all domains.

37. In the morning session on Day Two, Dr. Regina Wang gave Respondent a score of superior in all domains, except in the domain of ability to access evidence-based medicine, which she rated as satisfactory. In the afternoon session, Dr. Geneen Gin gave Respondent a rating of superior in all domains. On Day Three, Dr. Bazzo gave Respondent a score of superior in the domains of promptness, appearance, and professional behavior, and gave him a score of satisfactory in the domains of participation, communication skills, and medical knowledge.

38. In the morning session on Day Four, Dr. Kurtis Linderman gave Respondent a score of superior in the categories of promptness, appearance, professional behavior, communication skills, and ability to access evidence-based medicine. He gave Respondent a score of satisfactory in the domains of participation and medical knowledge. In the afternoon session, Dr. Esmatullah Hatamy gave Respondent a score of satisfactory in all categories, and commented that Respondent could benefit from a refresher course in primary care.

39. In the morning session on Day Five, Dr. Robert Y. Lee gave Respondent a score of superior in the categories of promptness, appearance, communication skills, medical knowledge, and ability to access evidence-based medicine, and gave him a score of unsatisfactory in the category of professional behavior. Dr. Lee noted Respondent was distracted and disinterested several times, and at other times, he was attentive and interactive. Dr. Lee noted that he witnessed Respondent on his telephone searching non-medical information during patient encounters and also dozing off during other patient encounters. During the afternoon session, Dr. Lee gave Respondent a score of superior in the categories of promptness, appearance, communication skills, medical knowledge, and ability to access evidence-based medicine. He gave Respondent a score of satisfactory in the participation domain, and gave him a score of unsatisfactory in the category of professional behavior. Dr. Lee noted that in between patient encounters, Respondent asked to take a break from shadowing and asked to be relieved from accompanying Dr. Lee for the next patient so Respondent could rest. Additionally, without advanced notice, Respondent asked to leave the session early, noting he was going to visit relatives and then head back home.

40. With respect to his evidence-based medicine project, PACE provided Respondent with resources, instruction, and an example evidence-based medicine project. Respondent completed a project on the topic of coma scales. However, after PACE submitted the project to Turnitin, which is a program designed to detect plagiarism, it determined that 87 percent of Respondent's evidence-based medicine project had been plagiarized.

41. Respondent was subjected to a PULSE 360 Degree Workplace Assessment, which consisted of 14 raters, including Respondent's self-rating, providing feedback of their perceptions of Respondent's leadership, teamwork, and practice style. All of the raters were individuals who worked with Respondent at Simi Health Center. All raters provided highly favorable ratings, particularly in the areas of treating team members with respect, being truthful and straightforward, and proactively and effectively teaching all team members.

42. Overall, Respondent's performance on the Phase 2 assessment was unsatisfactory. In addition to performing unsatisfactorily on the assessments, PACE considered Dr. Perry's neuropsychological evaluation report, and expressed grave concerns about Respondent's ability to

safely practice medicine. PACE also determined that Respondent should cease the practice of medicine until such time that he has been deemed fit to practice following an independent fitness for duty evaluation. It was recommended that the fitness for duty evaluation should include, at a bare minimum, a repeat neuropsychological evaluation and complete a neurological examination.

43. Dr. Norcross noted that Respondent's overall score on PACE's comprehensive Phase 1 and Phase 2 physician assessment was consistent with a "Fail-Category 4." Dr. Norcross explained that Category 4 signifies a poor performance that is not compatible with overall physician competency and safe practice. Alternatively, the physician could have a physical or mental health problem that prevents him or her from practicing safely. These physicians are unsafe and, based on the observed performance in the PACE assessment, represent a potential danger to their patients. Some physicians in this category may be capable of remediating their clinical competency to a safe level and some may not. Dr. Norcross emphasized that the PACE faculty does not give an outcome of "Fail" lightly or casually. This assignment reflects major, significant deficiencies in clinical competence, and physicians who receive this outcome, if deemed candidates for remedial education, should think in terms of engaging in a minimum of one year of dedicated study and other learning activities of no fewer than 30 to 40 hours per week.

#### *Neurocognitive Evaluation Report*

44. Dr. Kim Barrus, who has been a licensed clinical psychologist since 1979, and trained at Brigham Young University, performed, at Respondent's request, neurocognitive testing on Respondent over a period of three days, in September 2015. The purpose of the evaluation was to assess Respondent's cognitive strengths and weaknesses, due to the concern raised at PACE about his ability to practice as a physician.

45. Dr. Barrus administered the Wechsler Adult Intelligence Scale – Fourth Edition (WAIS-IV) to Respondent. With respect to his general intellectual ability, Dr. Barrus found difficult to summarize Respondent's overall intellectual functioning. His verbal reasoning abilities were better developed than his nonverbal reasoning skills. With respect to verbal comprehension, Respondent's verbal reasoning abilities were in the very superior range. Respondent's perceptual reasoning abilities were in the average range, and his working memory (i.e., the ability to sustain attention, concentrate, and exert mental control) was in the average range. Dr. Barrus found that Respondent's abilities to sustain attention, concentrate, and exert mental control were a weakness relative to his verbal reasoning abilities, and opined that a relative weakness in mental control may make the processing of complex information more time-consuming for Respondent, draining his mental energies more quickly as compared to others at his level of ability, and perhaps result in more frequent errors on a variety of learning or complex work tasks.

46. With respect to processing speed, Respondent's ability in processing simple or routine visual material without making errors is in the low average range. This weakness in simple visual scanning and tracking may leave Respondent less time and mental energy for the complex task of understanding new material.

47. Dr. Barrus administered a Test of Premorbid Functioning to compare actual versus equated or estimated premorbid standard scores of cognitive ability. Respondent's scores were higher than the estimated values with respect to verbal cognitive ability to reason and learn, but significantly lower with respect to perceptual reasoning ability to learn and cognitive processing speed.

48. Dr. Barrus administered the Woodcock Johnson III Test of Achievement. Respondent's English oral language skills were average when compared to others at his age, his academic skills were superior, and his fluency with academic tasks was average. When compared to others at his age level, Respondent's performance was superior in mathematics and math calculation skills, and average in broad reading.

49. Dr. Barrus administered the Shipley-II Test, which is used to screen general cognitive ability and to assess impairment due to dementia, cognitive decline, head trauma, and learning disabilities. The test results indicated that Respondent had normal cognitive ability to reason verbally and normal ability to reason perceptually/non-verbally.

50. With respect to executive processes, which include various kinds of judgments (e.g., comparisons, analyzing, planning, organizing, decision-making, and impulse control), Dr. Barrus administered the Conner's Continuous Performance Test II. The results showed Respondent's sustained attention and impulse control were poor. Dr. Barrus expressed that these results suggested that Respondent may be at risk for impaired executive functions which compromise his sustained attention and impulse control.

51. With respect to working memory, Dr. Barrus administered the Auditory Consonant Trigram Test. Working memory is the ability to remember something long enough to do something with it, like memorize it, follow directions, write down directions, write down a phone number, or take notes in a classroom. The results of the test showed Respondent scored in the average range, showing he had no working memory problem.

52. Dr. Barrus administered the Stroop Test, which is a test of concentration. The results showed that Respondent had difficulty with the reading and processing of words, suggesting his concentration and focus may be impaired consistent with an attention problem. Dr. Barrus also administered the Wisconsin Card Sorting Test, which yielded results showing Respondent had a normal ability to form abstract concepts fundamental to problem solving.

53. Dr. Barrus administered the CNS Vital Signs Neurocognitive Assessment Battery, which showed Respondent has problems with his motor speed and verbal memory and executive functions, such as sustained attention. He also administered the California Verbal Learning Test, which measures explicit short term and long term memory encoding, storage, and retrieval. The results indicated that Respondent's short term and long term memory encoding and retrieval were not within normal limits, showing a probable impairment.

54. Dr. Barrus administered the Rey-Osterrieth Complex Figure Test, which is a visual memory test that provides an assessment for a variety of cognitive processes, including planning,

organizational skills and problem solving strategies, as well as perceptual, motor, and episodic memory functions. The results of this test showed Respondent's visual memory encoding and retrieval were not impaired. Dr. Barrus also administered the Lafayette Groove Peg Board Test, which is a test of eye-hand motor coordination. The results of this test showed Respondent's fine motor dexterity and eye-hand coordination were both within normal limits bilaterally.

55. Dr. Barrus administered the Minnesota Multiphasic Personality Inventory, which is a clinical testing instrument used to assess personality. The test results yielded no psychopathology or personality disorders. Finally, Dr. Barrus administered the System Checklist-90, the results of which showed no symptoms of a psychiatric nature with respect to somatic complaints, obsessive-compulsive disorder, interpersonal sensitivity, depression, anxiety, anger, hospitality problems fears, phobias, paranoias, or psychotic thinking.

56. Dr. Barrus diagnosed Respondent with mild frontotemporal neurocognitive disorder, attention-deficit hyperactivity disorder (ADHD), and possible major frontotemporal neurocognitive disorder, but no loss of IQ or ability to learn and reason abstractly.

57. At hearing, Dr. Norcross explained that mild frontotemporal neurocognitive disorder diagnosed by Dr. Barrus does not mean "mild" in the generic sense. Rather, this diagnosis is a serious and significant one.

58. Dr. Barrus recommended that Respondent begin taking a stimulant medication targeting his executive functions and prefrontal cortex to help mitigate poor attention, processing, and concentration. By helping Respondent stay focused and sustain attention, he would be able to utilize his working memory more efficiently, and encode and retrieve information more effectively. Additionally, Dr. Barrus recommended that Respondent utilize web-based training exercises for verbal memory, such as Lumosity, Cogmed, or Dakim Brain Fitness. Finally, Dr. Barrus recommended retesting in six months to determine the stability of the test results of the entire assessment.

59. After his neurocognitive assessment in September 2015, Respondent began treating with Dr. Barrus immediately. Respondent began engaging in daily memory retraining. Additionally, Dr. Barrus prescribed Vyvanse to Respondent to address his ADHD. At hearing, upon learning about Dr. Barrus' treatment, Dr. Perry explained that Vyvanse is a stimulant used for attentional disorders, and not used to address memory loss. He further explained that Respondent's memory problems stem from his neurocognitive disorder that does not improve with stimulants.

60. On January 19, 2016, Dr. Barrus prepared a report stating Respondent had made some modest progress as a result of his daily memory training, and made exceptional progress in the area of taking a reliable medical history from memory without taking notes. This report included no evidence of testing or scoring. Dr. Barrus expressed confidence that Respondent would be able to resume his practice as a physician. Dr. Barrus recommended that Respondent practice in a group setting where Respondent would have colleagues available with whom he can consult. Dr. Barrus recommended that Respondent continue taking Vyvanse and doing his daily training of memory and executive functions. Dr. Barrus recommended that Respondent be retested in six months to assess

the stability of his cognitive functioning.

61. On February 1, 2017, Dr. Barrus prepared a report stating that Respondent's severe ADHD and disruption of executive functions were treated very successfully with Vyvanse. Additionally, he stated that Respondent had been participating in three or four sessions per week of REHCOM, which is an FDA-approved software memory retraining program designed to help individuals with memory encoding problems. Dr. Barrus explained that the memory program is used to help stroke and memory patients. Dr. Barrus stated Respondent's scores had risen to stabilize in the average range. This report included no evidence of administration of any tests. However, Dr. Barrus offered that, as Respondent continued to take his medication and engage in memory training, Respondent stabilized at this point with adequate ability to encode and retrieve verbal information, and, therefore, considered Respondent's memory loss in remission.

62. Dr. Perry explained that there is significant controversy regarding the effectiveness of memory training exercises, and, as such, memory training programs are not used widely. Dr. Perry further explained that if an individual is tested with the same material, it is expected that the person would improve in remembering that material. Dr. Perry expressed that the neurocognitive deficit he found in Respondent cannot be remediated through memory training.

#### *Neurological Report*

63. At Respondent request, on September 16, 2015, Dr. Arthur P. Kowell performed a neurological evaluation on Respondent and prepared a written report. Dr. Kowell did not testify at hearing, but did submit a declaration in opposition to a previous petition for interim suspension filed by Complainant. Dr. Kowell is a board certified neurologist, licensed to practice since 1975. He has also served as a clinical professor of neurology at the Davis Geffen School of Medicine at UCLA since 1992. Dr. Kowell earned his bachelor's degree in pre-med from Johns Hopkins University in 1968. He earned his doctor of medicine from the University of Pennsylvania, School of Medicine, in 1974, and earned his doctorate in anatomy from the University of Pennsylvania, Graduate School of Arts and Sciences, in 1974. Dr. Kowell completed his residency at UCLA Hospital in 1978. He has authored a number of published articles and papers. Dr. Kowell has special training in the diagnosis and treatment of diseases of the nervous system, and is familiar with physician competency assessment and the impact of neurological disorders on the same.

64. Dr. Kowell administered a Mini-Mental State Exam in which Respondent scored in the lower limit of normal for Respondent's age, sex, and level of education. Additionally, on the Test Your Memory Test, Respondent scored in the lower limit of normal for his age. On the Test Your Memory Test, Respondent forgot to read the instruction for one of the items on the first page of the test, which affected his ability to successfully complete an item on the second page of the test. The remainder of Respondent's neurological examination was within normal limits. Dr. Kowell concluded that the neurological examination revealed no strong evidence of dementia or degenerative process involving Respondent's central nervous system. However, Dr. Kowell declined from rendering a final opinion regarding Respondent's neurologic condition without further evaluation.

65. Dr. Kowell advised Respondent to do seven tasks: (1) provide records to Dr. Kowell regarding his previous evaluation concerning his mental status (i.e., report prepared by Dr. Barrus); (2) undergo neuropsychological testing; (3) undergo an MRI of the brain including NeuroQuant analysis with and without contrast; (4) undergo an awake electroencephalogram (EEG); (5) undergo a FDG-PET scan of the brain; (6) submit to blood testing; and (7) return for a follow-up visit after the completion of the studies listed above.

66. On October 9, 2015, Respondent underwent an awake EEG, which yielded normal results. On December 24, 2015, Respondent underwent an MRI of the brain, which revealed that Respondent's ventricles were mildly prominent with proportionate cortical atrophy. The degree of ventricular enlargement was statically significant for Respondent's age (i.e., greater than 99 percent).

67. A FDG-PET CT scan of the brain on December 30, 2015 revealed evidence of statistically significant cortical hypometabolism of the bilateral temporal lobes. Hypometabolism was also detected in bilateral anterior and posterior cingulate gyri. Borderline hypometabolism was also detected in the cerebellum. Structural imaging of the brain also demonstrated ventricular enlargement out of proportion in size to the appearance of the high convexity sulci, a finding which may well represent mild cerebral atrophy with a strong central predilection. The scan also showed mild to moderate cerebellar volume loss.

68. On January 11, 2016, Dr. Kowell prepared a report summarizing Dr. Barrus' report, the MRI results, and EEG, and the FDG-PET CT scan, among other things. Dr. Kowell opined that Respondent had no medical or mental condition that impairs his ability to safely practice medicine. Dr. Kowell indicated that Respondent should undergo periodic neuropsychological evaluation to monitor him for the possibility that he might develop a progressive neurodegenerative disorder, such as Alzheimer's disease.

#### *Independent Medical Evaluation Report*

69. On November 30, 2015, Complainant presented an ex parte petition for an interim order of suspension of Respondent's physician's and surgeon's certificate. Administrative Law Judge (ALJ), Ralph B. Dash, read and considered the ex parte petition, and heard argument of counsel. ALJ Dash ordered Respondent to be examined by a physician and/or psychologist in the Department of Gerontology at the University of California at Los Angeles (UCLA), School of Medicine, to determine whether his ability to practice medicine safely was impaired due to mental or physical illness affecting competency. ALJ Dash further ordered that the examining doctor shall not be called to testify at any stage of these proceedings.

70. On February 22, 2016, Respondent was evaluated by Dr. Peifeng Perry Hu of the UCLA Division of Geriatric Medicine.

71. Dr. Hu conducted a clinical examination, as well as reviewed prior assessments and test results. Dr. Hu found that Respondent's diagnosis of mild neurocognitive disorder was consistent with Dr. Hu's clinical examination and Respondent's PET/CT scan, which demonstrated

evidence of statistically significant cortical hypometabolism of the bilateral temporal lobes and bilateral anterior and posterior cingulate gyri. As such, Dr. Hu concluded Respondent had some level of mild neurocognitive disorder. Dr. Hu also noted from his review of reports that both Dr. Barrus and Dr. Kowell have indicated that Respondent can practice medicine safely right now. Dr. Hu agreed with Dr. Barrus' recommendation that Respondent practice in a group setting and have the availability of consultation with colleagues.

72. Dr. Hu also noted that Respondent, who exercised more than two hours per day, had no physical illness that currently limited his ability to practice medicine. At hearing, Respondent testified that since attending PACE and learning he had a mild cognitive impairment, he made up his mind to do whatever he needed to do to maintain his abilities. Consequently, Respondent adopted a management routine that included waking up early in the morning, walking uphill for approximately five miles, eating breakfast, going to the gym for weight lifting, and then visiting Dr. Barrus' office for one to two hours to undergo memory training. Respondent also takes Vyvanse and vitamins.

73. Dr. Hu made four recommendations: (1) Respondent resume his medical practice in the group setting, under the supervision of Dr. Joshi and other physician colleagues; (2) Respondent continue daily cognitive training and Vyvanse; (3) Respondent undergo neuropsychological evaluations every six months in order to continue monitoring Respondent's cognitive functions; and (4) Respondent continue to undergoing regular follow-up appointments with his psychologist, neurologist, and internist.

#### *Character Testimony*

74. Dr. Chandrashekhar Joshi is a physician licensed since 1973 and specializes in internal medicine and primary urgent care. Dr. Joshi has known Respondent for more than 40 years. Dr. Joshi is the owner of Simi Health Center and employed Respondent in approximately 2009 as a part-time physician. In that capacity, Dr. Joshi has observed Respondent practice medicine and finds Respondent to be very qualified.

75. Dr. Joshi is also Respondent's treating physician and treats him for ADHD and high blood pressure, and prescribes medication to Respondent for both conditions. Dr. Joshi has not been specifically trained in the area of mild cognitive impairment, but has seen Respondent practice and finds him totally competent in how he treats, diagnoses, and prescribes medication to patients. Dr. Joshi has not observed Respondent demonstrating difficulty in remembering the flow in conversations or remembering patient names.

#### CONCLUSIONS OF LAW

1. Cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2234, subdivision (d), for incompetence, as set forth in Findings 3 through 43.

## *The Applicable Law*

2. The standard of proof which must be met to establish the charging allegations herein is “clear and convincing evidence.” (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853.) This means the burden rests with Complainant to offer proof that is clear, explicit and unequivocal--so clear as to leave no substantial doubt and sufficiently strong to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

3. The purpose of the Medical Practice Act<sup>2</sup> is to assure the high quality of medical practice; in other words, to keep unqualified and undesirable persons and those guilty of unprofessional conduct out of the medical profession. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App. 3d 564, 574.) The imposition of license discipline does not depend on whether patients were injured by unprofessional medical practices. (See, *Bryce v. Board of Medical Quality Assurance* (1986) 184 Cal.App.3d. 1471; *Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.) Our courts have long held that the purpose of physician discipline by the Board is not penal but to “protect the life, health and welfare of the people at large and to set up a plan whereby those who practice medicine will have the qualifications which will prevent, as far as possible, the evils which could result from ignorance or incompetency or a lack of honesty and integrity.” (*Furnish v. Board of Medical Examiners* (1957) 149 Cal.App.2d 326, 331.

4. Business and Professions Code section 2234 states that the Board shall take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct includes (b) gross negligence; (c) repeated negligent acts (two or more negligent acts); (d) incompetence; and (e) the commission of any act involving dishonesty which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

5. The terms “negligent” and “incompetent” are not synonymous. Incompetence has been defined as a “general lack of present ability to perform a given duty as distinguished from inability to perform such duty as a result of mere neglect or omission.” (*Pollak v. Kinder* (1978) 85 Cal.App.3d 833, 837-838.) “[A] licensee may be competent or capable of performing a given duty but negligent in performing that duty.” (*Id.* at p. 838; see also, *James v. Bd. of Dental Examiners* (1985) 172 Cal.App.3d 1096, 1109 [“Incompetence generally is defined as a lack of knowledge or ability in the discharge of professional obligations”].) “Repeated negligent acts” is defined as two or more acts of negligence. (*Zabetian v. Medical Bd.* (2000) 80 Cal.App.4th 462, 468.)

6. California Code of Regulations, title 16, section 1360, states that for the purposes of denial, suspension or revocation of a license, an act shall be considered to be substantially related to the qualifications, functions or duties of a licensee if to a substantial degree it evidences present or potential unfitness to perform the functions authorized by the license in a manner consistent with the public health, safety or welfare. Such acts include violating any provision of the Medical Practice Act.

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<sup>2</sup> Business and Professions Code sections 2000 through 2521.

## *Analysis*

7. Complainant met her burden of establishing, by clear and convincing evidence, that Respondent lacks competence to perform the duties of a physician, by virtue of Respondent's failure to successfully pass the PACE program. The evidence clearly shows from the credible testimony of Dr. Norcross that Respondent's performance was substandard in both Phase 1 and Phase 2 of PACE. Specifically, in Phase 1, Respondent's history and physical exam were unsatisfactory, his chart reviews were unsatisfactory, his score on PRIMUM was in the first quintile, his score on the three written exams was in the first percentile, his behavior was sometimes unprofessional, and his Microcog screening indicated a need for further evaluation. In that regard, according to the credible testimony of Dr. Perry and the results of the neuropsychological evaluation administered by him, Respondent suffers from mild neurocognitive impairment, constituting concern for Respondent's ability to practice medicine in a manner that poses no potential danger to his patients.

8. In Phase 2, Respondent's performance was deemed unsatisfactory. Specifically, during clinical observations, Respondent was at times disinterested and falling asleep, his clinical judgment and overall clinical competence scores were unsatisfactory in some cases, and Respondent submitted a plagiarized evidence-based medicine project. Given the above factors, Complainant established her burden of demonstrating cause exists to discipline Respondent's certificate.

9. However, the evidence shows that despite the presence of mild neurocognitive impairment and cortical atrophy, Respondent is able to safely practice at this time. Specifically, Dr. Hu, who completed the independent medical evaluation, as well as Dr. Barras and Dr. Kowell, individually opined that Respondent can practice safely at this time, based on the results of his neurocognitive and neurological testing. In fact, Dr. Hu and Dr. Barras made similar recommendations to ensure Respondent's ability to practice medicine safely: (1) Respondent resume his medical practice in the group setting, under the supervision of Dr. Joshi and other physician colleagues; (2) Respondent continue daily cognitive training and Vyvanse; (3) Respondent undergo neuropsychological evaluations every six months in order to continue monitoring Respondent cognitive functions; and (4) Respondent continue to go to regular follow-up appointments with his psychologist, neurologist, and internist. Given these factors, the public will be adequately protected by the imposition of a period of probation that includes conditions similar to the ones recommended by Dr. Barras and Dr. Hu.

10. These types of cases are difficult, and the Panel is cognizant of its obligation to protect the public and aid in the rehabilitation of the licensee. (See Bus. & Prof. Code, §§ 2001.1, 2229.) Accordingly, the Panel will not lengthen the term of probation but make the terms and conditions of probation more comprehensive by adding three specific provisions. First, if a neuropsychological evaluation indicates the Respondent cannot practice medicine safely and independently, Respondent shall cease practice. Second, the addition of a practice monitor for the first two years of probation following the effective of this decision is ordered. Third, educational coursework will be required. The inclusion of the last two items in a probationary order is consistent with the Board's 2016 Disciplinary Guidelines whenever a charge of incompetence is

sustained and are aimed at the issues identified in Paragraphs 17, 18, 19, 20, 34, 38, and 43 of the Factual Findings.

## ORDER

Certificate No. A26513 issued to Respondent, Felix Louis Negron, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for five years, upon the following terms and conditions:

### **1. Neuropsychological and Neurological Evaluations and Treatment**

Within 30 calendar days of the effective date of this Decision, and every six months thereafter, Respondent shall undergo neuropsychological and neurological evaluations by a Board-appointed clinical neuropsychologist and a Board-appointed neurologist, respectfully, who shall consider any information provided by the Board or designee and any other information the evaluating physician deems relevant and shall furnish a medical report to the Board or its designee. Respondent shall provide the evaluating neuropsychologist and neurologist any information and documentation that the evaluating neuropsychologist and neurologist may deem pertinent. Following the evaluation, Respondent shall comply with all restrictions or conditions recommended by the evaluating neuropsychologist and neurologist, including the continued consumption of prescribed stimulants and the daily engagement in memory training, within 15 calendar days after being notified by the Board or its designee. If Respondent is required by the Board or its designee to undergo medical treatment (neuropsychological, neurological, or otherwise), Respondent shall within 30 calendar days of the requirement notice, submit to the Board or its designee for prior approval the name and qualifications of a California licensed treating physician(s) of Respondent's choice. Upon approval of the treating physician(s), Respondent shall within 15 calendar days undertake medical treatment and shall continue such treatment until further notice from the Board or its designee.

The treating physician(s) shall consider any information provided by the Board or its designee or any other information the treating physician(s) may deem pertinent prior to commencement of treatment. Respondent shall have the treating physician(s) submit quarterly reports to the Board or its designee indicating whether or not the Respondent is capable of practicing medicine safely. Respondent shall provide the Board or its designee with any and all medical records pertaining to treatment, the Board or its designee deems necessary.

If, prior to the completion of probation, Respondent is found to be physically incapable of resuming the practice of medicine without restrictions, Respondent shall not engage in the practice of medicine until notified in writing by the Board or its designee of its determination that respondent is medically fit to practice safely. If such a finding is made, the Board shall retain continuing jurisdiction over Respondent's license and the period of probation shall be extended until the Board determines that Respondent is physically capable of resuming the practice of medicine without restrictions. Respondent shall pay the cost of the neuropsychological and neurological evaluation(s) and treatment.

## **2. Education Course**

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. Specifically, 25 of the 40 hours shall be focused upon family practice. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

## **3. Monitoring - Practice**

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, respondent's practice shall be monitored by the approved monitor for the first two years of probation. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine, and whether respondent is practicing medicine safely. It shall be

the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, respondent may participate in a professional enhancement program approved in advance by the Board or its designee, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

#### **4. Solo Practice Prohibition**

Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: (1) Respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or (2) Respondent is the sole physician practitioner at that location. Respondent must practice in a group setting that will subject Respondent's work to daily review by his peer(s) as part of a quality assurance peer review process.

If Respondent fails to establish a practice with another physician(s) or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, the Respondent's practice setting changes and the Respondent is no longer practicing in a setting in compliance with this Decision, the Respondent shall notify the Board or its designee within five calendar days of the practice setting change. If Respondent fails to establish a practice with another physician(s) or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established.

#### **5. Notification**

Within seven days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every

hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change in hospitals, other facilities, or insurance carrier.

## **6 Supervision of Physician Assistants and Advanced Practice Nurses**

During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

## **7. Obey All Laws**

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

## **8. Quarterly Declarations**

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

## **9. General Probation Requirements**

### *Compliance with Probation Unit*

Respondent shall comply with the Board's probation unit.

### *Address Changes*

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

### *Place of Practice*

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

### *License Renewal*

Respondent shall maintain a current and renewed California physician's and surgeon's license.

### *Travel or Residence Outside California*

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

## **10. Interview with the Board or its Designee**

Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

## **11. Non-practice While on Probation**

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two years. Periods of non-practice will not apply to the reduction of the probationary term. Periods of non-practice for a Respondent residing outside of California, will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

## **12. Completion of Probation**

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

## **13. Violation of Probation**

Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

## **14. License Surrender**

Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

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**15. Probation Monitoring Costs**

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

This Decision shall become effective at 5:00 p.m. on SEPTEMBER 21, 2017.

IT IS SO ORDERED AUGUST 22, 2017.



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Michelle Anne Bholat, M.D., Chair  
Panel B

**BEFORE THE  
MEDICAL BOARD OF CALIFORNIA  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA**

In the Matter of Accusation Against: )

FELIX LOUIS NEGRON, M.D. )

Physician's & Surgeon's )

Certificate No: A26513 )

Respondent )

Case No.: 800-2016-020748

OAH No.: 2016090691

**ORDER OF NON-ADOPTION  
OF PROPOSED DECISION**

The Proposed Decision of the Administrative Law Judge in the above-entitled matter has been **non-adopted**. A panel of the Medical Board of California (Board) will decide the case upon the record, including the transcript and exhibits of the hearing, and upon such written argument as the parties may wish to submit directed to the question of whether the level of discipline imposed is sufficient to protect the public and whether it should be modified. The parties will be notified of the date for submission of such argument when the transcript of the above-mentioned hearing becomes available.

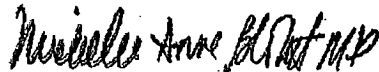
To order a copy of the transcript, please contact Kennedy Court Reporters, 920 West 17<sup>th</sup> Street, 2<sup>nd</sup> Floor, Santa Ana, California 92706. The telephone number is (916) 498-9288. To order a copy of the exhibits, please submit a written request to this Board.

**In addition, oral argument will only be scheduled if a party files a request for oral argument with the Board within 20 days from the date of this notice.** If a timely request is filed, the Board will serve all parties with written notice of the time, date and place for oral argument. Oral argument shall be directed only to the question of whether the proposed penalty should be modified. Please do not attach to your written argument any documents that are not part of the record as they cannot be considered by the Panel. The Board directs the parties attention to Title 16 of the California Code of Regulations, sections 1364.30 and 1364.32 for additional requirements regarding the submission of oral and written argument.

Please remember to serve the opposing party with a copy of your written argument and any other papers you might file with the Board. The mailing address of the Board is as follows:

MEDICAL BOARD OF CALIFORNIA  
2005 Evergreen Street, Suite 1200  
Sacramento, CA 95815-3831  
(916) 576-3216  
Attention: Robyn Fitzwater

Date: May 8, 2017



Michelle Bholat, M.D., Chair  
Panel B

BEFORE THE  
MEDICAL BOARD OF CALIFORNIA  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

FELIX LOUIS NEGRON, M.D.,  
Physician's and Surgeon's Certificate  
Number A26513,

Respondent.

Case No. 800-2016-020748

OAH No. 2016090691

**PROPOSED DECISION**

Administrative Law Judge Carla L. Garrett heard this matter on February 6 and 7, 2017, at Los Angeles, California.

Cindy M. Lopez, Deputy Attorney General, represented Complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California (Board). James T. Studer, Attorney at Law, represented Felix Louis Negron, M.D. (Respondent), who was present at hearing.

Oral and documentary evidence was received, the record was closed, and the matter was submitted for decision on February 7, 2017.

**FINDINGS OF FACT**

1. Complainant made the Accusation in her official capacity as Executive Director of the Board.
2. The Board issued Physician's and Surgeon's Certificate Number A26513 to Respondent on February 11, 1975. The certificate expired on November 30, 2016 and is in a delinquent status.

*Preliminary Background Information*

3. In a disciplinary action entitled *In the Matter of the Accusation Against Felix Louis Negron, M.D.*, Case No. 05-2011-217285, Complainant alleged Respondent engaged in gross negligence and repeated acts of negligence in the care and treatment of a patient.

Specifically, Complainant alleged Respondent treated a patient with antibiotics without an established clinical basis upon which to justify such an action. Additionally, Complainant alleged Respondent destroyed all of the patient's records.

4. The Board, pursuant to a stipulated settlement reached between Complainant and Respondent, issued a decision effective November 14, 2014 that publically reprimanded Respondent's certificate, subject to terms and conditions. Those conditions included a requirement that Respondent successfully complete the Medical Record-Keeping course and the Physician Assessment and Clinical Education (PACE) program at the University of California at San Diego (UCSD).

#### *PACE Program Background*

5. Dr. William Norcross, who has been a board certified physician in family medicine since 1977, is the founder of PACE. Dr. Norcross testified at hearing. Dr. Norcross earned his bachelor's degree in chemistry from Ursinus College in 1970, and his doctor of medicine from Duke University School of Medicine in 1974. Dr. Norcross completed his residency at UCSD in 1977. Dr. Norcross, in addition to being the director at PACE, has been a clinical professor of family medicine at UCSD School of Medicine since 2007. He has served in a number of other academic positions, and has been the recipient of a number of awards, including San Diego Magazine's Best Doctors award for consecutive years between 2004 and 2015, and Physician of the Year at UCSD Medical Center. Dr. Norcross has given a number of presentations and lectures, and has authored a number of published letters and book chapters.

6. Dr. Norcross founded PACE in 1986. PACE is a program for the assessment of physician competence, the detection of problems or deficiencies, and, when possible, the remediation of those problems or deficiencies. There are six core domains of competence: (1) patient care; (2) medical knowledge; (3) practice-based learning and improvement; (4) communication; (5) professionalism; and (6) systems-based practice. All six competencies are evaluated during a physician's participation in PACE.

7. PACE is comprised of two phases. Phase 1 consists of multi-day testing in which physicians are required to do the following: (1) provide self-reporting measures; (2) perform a mock patient history and physical; (3) undergo a physical examination and mental health screening; (4) take a cognitive screening test; (5) undergo an oral clinical examination; (6) submit to a charts review; (7) take computer-delivered tests; (8) undergo a transaction stimulated recall interview; (9) take multiple choice exams; (10) take an ethics and communication examination; (11) take a mechanisms of disease exam; (12) take a family medicine clinical science subject exam; and (13) participate in an exit interview.

8. Phase 2 consists of multi-day testing that requires physicians to: (1) complete a standardized patient evaluation; (2) undergo a chart stimulated recall examination; (3)

perform in multi-day clinical sessions; (4) complete an evidence-based medicine project; and (5) undergo a Pulse 360 Degree Workplace Assessment.<sup>1</sup>

9. If a physician exhibits neurological issues, PACE makes a determination whether the physician must undergo neurological testing. Approximately 25 percent of physicians attending PACE are referred out neurological examinations.

10. A PACE committee of nine physicians and case managers reviews all of the results yielded from the Phase 1 and Phase 2 testing, and makes a determination whether a physician has passed or failed PACE. All committee members must be in full agreement. Approximately 87 percent of physicians pass PACE.

#### *PACE Phase 1*

11. Respondent participated in Phase 1 of PACE from February 3 through 4, 2015. During the mock patient history and physical examination, Respondent rushed through both the history and physical exam, seemed impatient when it came to listening to the patient, demonstrated a limited review of systems, and failed to ask any follow up questions. He asked very little about the patient's social history, but commented twice to the patient that she had beautiful hair. Overall, Respondent's performance of the history and physical was not deemed to be within the standard of care.

12. Dr. Sheila Pickwell, a clinical professor of family medicine and public health, performed a physical examination of Respondent, and other than an elevated blood pressure reading, found no health concerns or physical abnormalities. Although Dr. Pickwell and Respondent did not know each other, Respondent patted Dr. Pickwell on her stomach before the exam began, and touched her arm several times during the exam. At hearing, Respondent explained that he touched Dr. Pickwell's stomach as a result of role-playing in which Dr. Pickwell played a patient who had just undergone surgery, and Respondent touched her stomach during the mock examination.

13. Respondent completed a cognitive screening test using Microcog, which is a computer-based assessment of cognitive skills used to determine which PACE participants should be referred for a full neuropsychological evaluation. The test required some proficiency with computers; however, a proctor was available to answer questions about test instructions. With respect to Respondent, relative to a person of similar age and educational background, he performed in the low average range in the areas of general cognitive functioning, general cognitive proficiency, information processing speed, attention and mental control, reasoning and calculation, and spatial processing. He scored in the average range in the areas of information processing accuracy, memory, and reaction time. However, when compared to the general population, Respondent scored in the below average range in all areas except for memory and reaction time, which he scored in the low average range.

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<sup>1</sup> PULSE 360 Degree is a survey system designed to show healthcare professionals how they are viewed on core competencies.

14. Dr. Martin Schulman performed a one-hour oral examination on Respondent, in which Respondent was given six separate scenarios of patient issues, and asked to take histories of the patients, provide initial differential diagnosis of each patient's ailment(s), and propose a treatment plan. Respondent scored in the average range on all six scenarios, but Dr. Schulman noted Respondent tended to take incomplete histories of the patients, and, in a few of the scenarios, demonstrated a need for updating his approach to problem management.

15. Dr. Schulman also conducted a chart review of seven chart entries from Respondent. The global overall assessment showed that Respondent scored in the "meets standards" range for three charts, in the "caution/borderline" range for two charts, and in the "do not meet standards" range for two charts.

16. Respondent completed PRIMUM, which were computer-delivered tests to assess his knowledge of clinical decision-making and patient-management skills. PRIMUM consisted of a mix of eight urgent and non-urgent cases that Respondent was required to manage. Computer literacy was a factor on this exam, and, at hearing, Respondent testified he was not familiar with this type of testing and how to respond on the computer. However, Respondent had the opportunity to practice at home before coming to the assessment and to complete five practice cases before starting the actual exam. If requested, a proctor was also available to serve as a scribe on the keyboard or answer questions about how to maneuver around within the computer program. Respondent scored in the first or lowest quintile in all eight cases.

17. At the completion of the PRIMUM computer case simulations, Dr. Schulman interviewed Respondent to gain a better understanding of his performance. Respondent advised Dr. Schulman that his computer skills were at "about a 2 or 3 on a scale of 1 to 10," but Respondent never requested a proctor to type his responses for him. Out of the eight diagnoses, Respondent got three of them correct. Dr. Schulman noted Respondent demonstrated some deficiencies in his medical knowledge and clinical judgment, with an overall unsatisfactory performance. Dr. Schulman also noted that Respondent demonstrated some memory difficulties.

18. Respondent completed a 100-item multiple-choice test to assess medical knowledge and knowledge of ethics and communication. Respondent scored 59 percent on this exam, which was in the first percentile of the 2,000 physicians in the reference group who took the United States Medical Licensing Examination (USMLE) for the first time and who had completed one to three years of residency training.

19. Respondent completed a 120-item multiple-choice test that assessed applied basic science principles underlying medicine. Many of the questions were related to manifestations and symptoms of disease, particularly in the areas of behavioral science, anatomic structure, pathology and laboratory medicine, infectious disease and immunology, pathophysiology, and physiology and metabolism. Respondent scored 47 percent on this exam, which was in the first percentile of the 2,000 physicians in the reference group who

took the USMLE for the first time and who had completed one to three years of residency training.

20. Respondent completed a family medicine clinical science subject exam, designed to assess overall broad knowledge in the field of family medicine. Respondent's overall score was in the first percentile when compared to a reference group of 6,000 first-time takers from more than 55 schools who took the exam as their final clerkship examination.

21. Overall, Respondent's performance on the Phase 1 assessment was unsatisfactory. In addition to performing unsatisfactorily on the assessments, Dr. Norcross noted that Respondent also exhibited poor professionalism on several occasions. For example, Respondent patted Dr. Pickwell's stomach, touched her arm several times, and used profanity throughout his assessment and during his exit interview, and commented twice to the mock patient about her hair.

### *Neuropsychological Evaluation*

22. As a result of Respondent's performance on the cognitive screening test, PACE recommended that Respondent undergo a Fitness for Duty Evaluation (FFDE), which is a formal, specialized examination performed by a clinical neuropsychologist that assesses cognitive areas in order to objectively determine where there is evidence that a physician is unable to safely or effectively perform his or her defined duties. The central purpose of an FFDE is not to determine whether the physician meets a certain diagnosis, but rather whether they are able to function effectively as a physician, and in a manner conducive to public safety. PACE refers physicians for a FFDE when there is an objective and reasonable basis for believing that he or she may be unable to safely perform his or her duties due to a neurological/psychological condition or impairment.

23. Dr. William Perry, who is a licensed psychologist that performed Respondent's FFDE neuropsychological evaluation, testified at hearing. Dr. Perry earned his bachelor's degree from Hampshire College in 1979, and his doctorate from the California School of Professional Psychology, with honors, in 1989. Dr. Perry has served as chief psychologist at UCSD since 1998, the executive director at the National Academy of Neuropsychology since 2011, the co-director of the Division of Clinical Psychiatry at UCSD since 2015, and the vice-chair for the Operations and Program Development Department of Psychiatry at UCSD since 2015. He has also served as the professor in residence at UCSD since 2006. Dr. Perry has more than 125 published works.

24. Dr. Perry has conducted more than 1,000 evaluations of physicians associated with the PACE program. Dr. Perry does not administer the tests himself. Rather, Dr. Perry assigns to a post-doctoral fellow the task of administering the tests. Thereafter, Dr. Perry interprets the data.

25. Respondent underwent his neuropsychological evaluation on May 11, 2015. Dr. Perry prepared a written report dated May 23, 2015. Respondent performed adequately on effort measures and appeared to put forth adequate effort throughout neuropsychological testing. With respect to Respondent's general intellectual functioning, Respondent's premorbid level of general intellectual functioning fell within the average range, according to the results of his Test of Premorbid Functioning and Wechsler Abbreviated Scale of Intelligence (2nd Edition).

26. With respect to attention and concentration, which refers to a person's ability to focus for a sustained period of time, as well as mentally manipulate information held in short-term memory, Respondent's performance in this domain was impaired. Specifically, his performance on a task requiring sustained and selective visual attention was impaired, according to the results of his Test of Variables of Attention, and demonstrated significantly high variability in his response time. Respondent's performance on another measure of sustained attention (Digit Vigilance) was in the mildly impaired range in terms of errors and in the mildly to moderately impaired range in terms of time. Additionally, Respondent's working memory index fell within the moderately impaired range, his performance was within the mildly impaired range on a task requiring rote repetition and reversal of numbers, and his performance on a measure of mental arithmetic was in the moderately to severely impaired range.

27. With respect to processing speed and motor functioning, which refers to a person's efficiency in cognitively processing information and producing an output, Respondent's performance in this domain was impaired. His performance on a task requiring visual perception and speed fell within the mildly impaired range. On a task requiring basic sequencing, Respondent scored in the average range. Respondent's fine motor performance with his dominant hand fell within the low average range, while his performance with his non-dominant hand fell within the mildly impaired range.

28. With respect to language, which refers to a person's knowledge of English vocabulary as well as verbal reasoning skills, Respondent's performance in this domain was varied. His verbal abstract reasoning performance fell within the average range, and his performance on a measure of expressive knowledge of vocabulary words fell within the above average range. On a measure of confrontation naming, Respondent's performance fell within the mildly impaired range. Respondent's performance on a measure of letter fluency fell within the average range, while his performance on a measure of semantic fluency fell within the low average range.

29. With respect to visuospatial functioning, which refers to a person's ability to perceive the relationship of objects in space and manipulate them accurately, Respondent's performance in this domain was varied. His performance on spatial problem-solving skills fell within the average range, while his performance on a task of manually constructing designs in a timely fashion fell within the mildly impaired range.

30. With respect to learning and memory, which refers to a person's ability to learn new verbal and non-verbal information, and be able to adequately retrieve the information, store that information, and be able to adequately retrieve the information, Respondent's performance in this domain was impaired. On the California Verbal Learning Test (2nd Edition), Respondent scored within the mildly to moderately impaired range. His "short-delayed" free recall fell within the mildly to moderately impaired range, as did his "long-delayed" free recall performance. Respondent's recognition hits score fell within the severely impaired range, and his overall recognition discriminability score fell within the moderately impaired range. Respondent's total recall on learning and remembering visual materials fell within the moderately to severely impaired range, as was his delayed recall. His recognition discriminability performance fell within the moderately impaired range.

31. With respect to executive functioning, which refers to those cognitive abilities involved in planning, cognitive flexibility, abstract thinking, rule acquisition, initiating appropriate actions and inhibiting inappropriate actions, Respondent's performance in this domain varied. Specifically, on the Category Test, which requires multiple fundamental cognitive skills and higher-level executive functions, Respondent scored within the low average range. On a test requiring speed of information processing and cognitive switching, Respondent's performance fell within the mildly to moderately impaired range. On a measure of cognitive flexibility and novel problem solving, Respondent scored within normal limits.

32. With respect to emotional functioning, Respondent denied symptoms of depression or anxiety on self-report questionnaires of mood symptoms.

33. Dr. Perry concluded that, overall, Respondent's deficits on cognitive testing were of concern and sufficiently deficient that they constituted a concern for his independent practice of medicine. Dr. Perry recommended that Respondent seek a neurological evaluation and consider retesting in six months to determine the stability of the results of this neuropsychological evaluation.

#### *PACE Phase 2*

34. Respondent participated in Phase 2 of PACE from June 22 through 26, 2015. Respondent completed a standardized patient evaluation with Dr. David Bazzo and Dr. Schulman, who assessed Respondent's clinical competence in the areas of interviewing, conducting a physical examination, professionalism, clinical judgment, counseling, and organization. Respondent received an overall clinical competence score that fell within the average range, but Drs. Bazzo and Schulman found his clinical judgment and overall clinical competence scores unsatisfactory in some cases. They concluded Respondent needed to work on his physical examination skills and study ischemic neurological disease.

35. Dr. Bazzo conducted a chart stimulated recall exercise on Respondent, which entailed Dr. Bazzo reviewing 20 chart entries submitted by Respondent for patients examined by Respondent. Dr. Bazzo discussed each of the entries with Respondent, seven of

them in great detail. Dr. Bazzo found that, overall, Respondent's documentation needed improvement, as one must be able to recreate from the documentation the essence of the visit. Dr. Bazzo found that Respondent's thought process for the patients appeared intact.

36. Respondent engaged in clinical sessions, in which his performance was rated by PACE faculty with whom Respondent was assigned to shadow. The PACE faculty members addressed the domains of promptness, appearance, participation, professional behavior, communication skills, medical knowledge, and the ability to access evidence-based medicine. Most clinical sessions occurred in the morning and afternoon on five consecutive days. On Day One, Dr. Patricia Brady gave Respondent a rating of superior in all domains.

37. In the morning session on Day Two, Dr. Regina Wang gave Respondent a score of superior in all domains, except in the domain of ability to access evidence-based medicine, which she rated as satisfactory. In the afternoon session, Dr. Geneen Gin gave Respondent a rating of superior in all domains. On Day Three, Dr. Bazzo gave Respondent a score of superior in the domains of promptness, appearance, and professional behavior, and gave him a score of satisfactory in the domains of participation, communication skills, and medical knowledge.

38. In the morning session on Day Four, Dr. Kurtis Linderman gave Respondent a score of superior in the categories of promptness, appearance, professional behavior, communication skills, and ability to access evidence-based medicine. He gave Respondent a score of satisfactory in the domains of participation and medical knowledge. In the afternoon session, Dr. Esmatullah Hatamy gave Respondent a score of satisfactory in all categories, and commented that Respondent could benefit from a refresher course in primary care.

39. In the morning session on Day Five, Dr. Robert Y. Lee gave Respondent a score of superior in the categories of promptness, appearance, communication skills, medical knowledge, and ability to access evidence-based medicine, and gave him a score of unsatisfactory in the category of professional behavior. Dr. Lee noted Respondent was distracted and disinterested several times, and at other times, he was attentive and interactive. Dr. Lee noted that he witnessed Respondent on his telephone searching non-medical information during patient encounters and also dozing off during other patient encounters. During the afternoon session, Dr. Lee gave Respondent a score of superior in the categories of promptness, appearance, communication skills, medical knowledge, and ability to access evidence-based medicine. He gave Respondent a score of satisfactory in the participation domain, and gave him a score of unsatisfactory in the category of professional behavior. Dr. Lee noted that in between patient encounters, Respondent asked to take a break from shadowing and asked to be relieved from accompanying Dr. Lee for the next patient so Respondent could rest. Additionally, without advanced notice, Respondent asked to leave the session early, noting he was going to visit relatives and then head back home.

40. With respect to his evidence-based medicine project, PACE provided Respondent with resources, instruction, and an example evidence-based medicine project.

Respondent completed a project on the topic of coma scales. However, after PACE submitted the project to Turnitin, which is a program designed to detect plagiarism, it determined that 87 percent of Respondent's evidence-based medicine project had been plagiarized.

41. Respondent was subjected to a PULSE 360 Degree Workplace Assessment, which consisted of 14 raters, including Respondent's self-rating, providing feedback of their perceptions of Respondent's leadership, teamwork, and practice style. All of the raters were individuals who worked with Respondent at Simi Health Center. All raters provided highly favorable ratings, particularly in the areas of treating team members with respect, being truthful and straightforward, and proactively and effectively teaching all team members.

42. Overall, Respondent's performance on the Phase 2 assessment was unsatisfactory. In addition to performing unsatisfactorily on the assessments, PACE considered Dr. Perry's neuropsychological evaluation report, and expressed grave concerns about Respondent's ability to safely practice medicine. PACE also determined that Respondent should cease the practice of medicine until such time that he has been deemed fit to practice following an independent fitness for duty evaluation. It was recommended that the fitness for duty evaluation should include, at a bare minimum, a repeat neuropsychological evaluation and complete a neurological examination.

43. Dr. Norcross noted that Respondent's overall score on PACE's comprehensive Phase 1 and Phase 2 physician assessment was consistent with a "Fail-Category 4." Dr. Norcross explained that Category 4 signifies a poor performance that is not compatible with overall physician competency and safe practice. Alternatively, the physician could have a physical or mental health problem that prevents him or her from practicing safely. These physicians are unsafe and, based on the observed performance in the PACE assessment, represent a potential danger to their patients. Some physicians in this category may be capable of remediating their clinical competency to a safe level and some may not. Dr. Norcross emphasized that the PACE faculty does not give an outcome of "Fail" lightly or casually. This assignment reflects major, significant deficiencies in clinical competence, and physicians who receive this outcome, if deemed candidates for remedial education, should think in terms of engaging in a minimum of one year of dedicated study and other learning activities of no fewer than 30 to 40 hours per week.

#### *Neurocognitive Evaluation Report*

44. Dr. Kim Barrus, who has been a licensed clinical psychologist since 1979, and trained at Brigham Young University, performed, at Respondent's request, neurocognitive testing on Respondent over a period of three days, in September 2015. The purpose of the evaluation was to assess Respondent's cognitive strengths and weaknesses, due to the concern raised at PACE about his ability to practice as a physician.

45. Dr. Barrus administered the Wechsler Adult Intelligence Scale – Fourth 4th Edition (WAIS-IV) to Respondent. With respect to his general intellectual ability, Dr.

Barrus found difficult to summarize Respondent's overall intellectual functioning. His verbal reasoning abilities were better developed than his nonverbal reasoning skills. With respect to verbal comprehension, Respondent's verbal reasoning abilities were in the very superior range. Respondent's perceptual reasoning abilities were in the average range, and his working memory (i.e., the ability to sustain attention, concentrate, and exert mental control) was in the average range. Dr. Barrus found that Respondent's abilities to sustain attention, concentrate, and exert mental control were a weakness relative to his verbal reasoning abilities, and opined that a relative weakness in mental control may make the processing of complex information more time-consuming for Respondent, draining his mental energies more quickly as compared to others at his level of ability, and perhaps result in more frequent errors on a variety of learning or complex work tasks.

46. With respect to processing speed, Respondent's ability in processing simple or routine visual material without making errors is in the low average range. This weakness in simple visual scanning and tracking may leave Respondent less time and mental energy for the complex task of understanding new material.

47. Dr. Barrus administered a Test of Premorbid Functioning to compare actual versus equated or estimated premorbid standard scores of cognitive ability. Respondent's scores were higher than the estimated values with respect to verbal cognitive ability to reason and learn, but significantly lower with respect to perceptual reasoning ability to learn and cognitive processing speed.

48. Dr. Barrus administered the Woodcock Johnson III Test of Achievement. Respondent's English oral language skills were average when compared to others at his age, his academic skills were superior, and his fluency with academic tasks was average. When compared to others at his age level, Respondent's performance was superior in mathematics and math calculation skills, and average in broad reading.

49. Dr. Barrus administered the Shipley-II Test, which is used to screen general cognitive ability and to assess impairment due to dementia, cognitive decline, head trauma, and learning disabilities. The test results indicated that Respondent had normal cognitive ability to reason verbally and normal ability to reason perceptually/non-verbally.

50. With respect to executive processes, which include various kinds of judgments (e.g., comparisons, analyzing, planning, organizing, decision-making, and impulse control), Dr. Barrus administered the Conner's Continuous Performance Test II. The results showed Respondent's sustained attention and impulse control were poor. Dr. Barrus expressed that these results suggested that Respondent may be at risk for impaired executive functions which compromise his sustained attention and impulse control.

51. With respect to working memory, Dr. Barrus administered the Auditory Consonant Trigram Test. Working memory is the ability to remember something long enough to do something with it, like memorize it, follow directions, write down directions,

write down a phone number, or take notes in a classroom. The results of the test showed Respondent scored in the average range, showing he had no working memory problem.

52. Dr. Barrus administered the Stroop Test, which is a test of concentration. The results showed that Respondent had difficulty with the reading and processing of words, suggesting his concentration and focus may be impaired consistent with an attention problem. Dr. Barrus also administered the Wisconsin Card Sorting Test, which yielded results showing Respondent had a normal ability to form abstract concepts fundamental to problem solving.

53. Dr. Barrus administered the CNS Vital Signs Neurocognitive Assessment Battery, which showed Respondent has problems with his motor speed and verbal memory and executive functions, such as sustained attention. He also administered the California Verbal Learning Test, which measures explicit short term and long term memory encoding, storage, and retrieval. The results indicated that Respondent's short term and long term memory encoding and retrieval were not within normal limits, showing a probable impairment.

54. Dr. Barrus administered the Rey-Osterrieth Complex Figure Test, which is a visual memory test that provides an assessment for a variety of cognitive processes, including planning, organizational skills and problem solving strategies, as well as perceptual, motor, and episodic memory functions. The results of this test showed Respondent's visual memory encoding and retrieval were not impaired. Dr. Barrus also administered the Lafayette Groove Peg Board Test, which is a test of eye-hand motor coordination. The results of this test showed Respondent's fine motor dexterity and eye-hand coordination were both within normal limits bilaterally.

55. Dr. Barrus administered the Minnesota Multiphasic Personality Inventory, which is a clinical testing instrument used to assess personality. The test results yielded no psychopathology or personality disorders. Finally, Dr. Barrus administered the System Checklist-90, the results of which showed no symptoms of a psychiatric nature with respect to somatic complaints, obsessive-compulsive disorder, interpersonal sensitivity, depression, anxiety, anger, hospitality problems fears, phobias, paranoias, or psychotic thinking.

56. Dr. Barrus diagnosed Respondent with mild frontotemporal neurocognitive disorder, attention-deficit hyperactivity disorder (ADHD), and possible major frontotemporal neurocognitive disorder, but no loss of IQ or ability to learn and reason abstractly.

57. At hearing, Dr. Norcross explained that mild frontotemporal neurocognitive disorder diagnosed by Dr. Barrus does not mean "mild" in the generic sense. Rather, this diagnosis is a serious and significant one.

58. Dr. Barrus recommended that Respondent begin taking a stimulant medication targeting his executive functions and prefrontal cortex to help mitigate poor attention, processing, and concentration. By helping Respondent stay focused and sustain attention, he

would be able to utilize his working memory more efficiently, and encode and retrieve information more effectively. Additionally, Dr. Barrus recommended that Respondent utilize web-based training exercises for verbal memory, such as Lumosity, Cogmed, or Dakim Brain Fitness. Finally, Dr. Barrus recommended retesting in six months to determine the stability of the test results of the entire assessment.

59. After his neurocognitive assessment in September 2015, Respondent began treating with Dr. Barrus immediately. Respondent began engaging in daily memory retraining. Additionally, Dr. Barrus prescribed Vyvanse to Respondent to address his ADHD. At hearing, upon learning about Dr. Barrus' treatment, Dr. Perry explained that Vyvanse is a stimulant used for attentional disorders, and not used to address memory loss. He further explained that Respondent's memory problems stem from his neurocognitive disorder that does not improve with stimulants.

60. On January 19, 2016, Dr. Barrus prepared a report stating Respondent had made some modest progress as a result of his daily memory training, and made exceptional progress in the area of taking a reliable medical history from memory without taking notes. This report included no evidence of testing or scoring. Dr. Barrus expressed confidence that Respondent would be able to resume his practice as a physician. Dr. Barrus recommended that Respondent practice in a group setting where Respondent would have colleagues available with whom he can consult. Dr. Barrus recommended that Respondent continue taking Vyvanse and doing his daily training of memory and executive functions. Dr. Barrus recommended that Respondent be retested in six months to assess the stability of his cognitive functioning.

61. On February 1, 2017, Dr. Barrus prepared a report stating that Respondent's severe ADHD and disruption of executive functions were treated very successfully with Vyvanse. Additionally, he stated that Respondent had been participating in three or four sessions per week of REHCOM, which is an FDA-approved software memory retraining program designed to help individuals with memory encoding problems. Dr. Barrus explained that the memory program is used to help stroke and memory patients. Dr. Barrus stated Respondent's scores had risen to stabilize in the average range. This report included no evidence of administration of any tests. However, Dr. Barrus offered that, as Respondent continued to take his medication and engage in memory training, Respondent stabilized at this point with adequate ability to encode and retrieve verbal information, and, therefore, considered Respondent's memory loss in remission.

62. Dr. Perry explained that there is significant controversy regarding the effectiveness of memory training exercises, and, as such, memory training programs are not used widely. Dr. Perry further explained that if an individual is tested with the same material, it is expected that the person would improve in remembering that material. Dr. Perry expressed that the neurocognitive deficit he found in Respondent cannot be remediated through memory training.

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## *Neurological Report*

63. At Respondent request, on September 16, 2015, Dr. Arthur P. Kowell performed a neurological evaluation on Respondent and prepared a written report. Dr. Kowell did not testify at hearing, but did submit a declaration in opposition to a previous petition for interim suspension filed by Complainant. Dr. Kowell is a board certified neurologist, licensed to practice since 1975. He has also served as a clinical professor of neurology at the Davis Geffen School of Medicine at UCLA since 1992. Dr. Kowell earned his bachelor's degree in pre-med from Johns Hopkins University in 1968. He earned his doctor of medicine from the University of Pennsylvania, School of Medicine, in 1974, and earned his doctorate in anatomy from the University of Pennsylvania, Graduate School of Arts and Sciences, in 1974. Dr. Kowell completed his residency at UCLA Hospital in 1978. He has authored a number of published articles and papers. Dr. Kowell has special training in the diagnosis and treatment of diseases of the nervous system, and is familiar with physician competency assessment and the impact of neurological disorders on the same.

64. Dr. Kowell administered a Mini-Mental State Exam in which Respondent scored in the lower limit of normal for Respondent's age, sex, and level of education. Additionally, on the Test Your Memory Test, Respondent scored in the lower limit of normal for his age. On the Test Your Memory Test, Respondent forgot to read the instruction for one of the items on the first page of the test, which affected his ability to successfully complete an item on the second page of the test. The remainder of Respondent's neurological examination was within normal limits. Dr. Kowell concluded that the neurological examination revealed no strong evidence of dementia or degenerative process involving Respondent's central nervous system. However, Dr. Kowell declined from rendering a final opinion regarding Respondent's neurologic condition without further evaluation.

65. Dr. Kowell advised Respondent to do seven tasks: (1) provide records to Dr. Kowell regarding his previous evaluation concerning his mental status (i.e., report prepared by Dr. Barrus); (2) undergo neuropsychological testing; (3) undergo an MRI of the brain including NeuroQuant analysis with and without contrast; (4) undergo an awake electroencephalogram (EEG); (5) undergo a FDG-PET scan of the brain; (6) submit to blood testing; and (7) return for a follow-up visit after the completion of the studies listed above.

66. On October 9, 2015, Respondent underwent an awake EEG, which yielded normal results. On December 24, 2015, Respondent underwent an MRI of the brain, which revealed that Respondent's ventricles were mildly prominent with proportionate cortical atrophy. The degree of ventricular enlargement was statically significant for Respondent's age (i.e., greater than 99 percent).

67. A FDG-PET CT scan of the brain on December 30, 2015 revealed evidence of statistically significant cortical hypometabolism of the bilateral temporal lobes. Hypometabolism was also detected in bilateral anterior and posterior cingulate gyri. Borderline hypometabolism was also detected in the cerebellum. Structural imaging of the

brain also demonstrated ventricular enlargement out of proportion in size to the appearance of the high convexity sulci, a finding which may well represent mild cerebral atrophy with a strong central predilection. The scan also showed mild to moderate cerebellar volume loss.

68. On January 11, 2016, Dr. Kowell prepared a report summarizing Dr. Barrus' report, the MRI results, and EEG, and the FDG-PET CT scan, among other things. Dr. Kowell opined that Respondent had no medical or mental condition that impairs his ability to safely practice medicine. Dr. Kowell indicated that Respondent should undergo periodic neuropsychological evaluation to monitor him for the possibility that he might develop a progressive neurodegenerative disorder, such as Alzheimer's disease.

#### *Independent Medical Evaluation Report*

69. On November 30, 2015, Complainant presented an ex parte petition for an interim order of suspension of Respondent's physician's and surgeon's certificate. Administrative Law Judge (ALJ), Ralph B. Dash, read and considered the ex parte petition, and heard argument of counsel. ALJ Dash ordered Respondent to be examined by a physician and/or psychologist in the Department of Gerontology at the University of California at Los Angeles (UCLA), School of Medicine, to determine whether his ability to practice medicine safely was impaired due to mental or physical illness affecting competency. ALJ Dash further ordered that the examining doctor shall not be called to testify at any stage of these proceedings.

70. On February 22, 2016, Respondent was evaluated by Dr. Peifeng Perry Hu of the UCLA Division of Geriatric Medicine.

71. Dr. Hu conducted a clinical examination, as well as reviewed prior assessments and test results. Dr. Hu found that Respondent's diagnosis of mild neurocognitive disorder was consistent with Dr. Hu's clinical examination and Respondent's PET/CT scan, which demonstrated evidence of statistically significant cortical hypometabolism of the bilateral temporal lobes and bilateral anterior and posterior cingulate gyri. As such, Dr. Hu concluded Respondent had some level of mild neurocognitive disorder. Dr. Hu also noted from his review of reports that both Dr. Barrus and Dr. Kowell have indicated that Respondent can practice medicine safely right now. Dr. Hu agreed with Dr. Barrus' recommendation that Respondent practice in a group setting and have the availability of consultation with colleagues.

72. Dr. Hu also noted that Respondent, who exercised more than two hours per day, had no physical illness that currently limited his ability to practice medicine. At hearing, Respondent testified that since attending PACE and learning he had a mild cognitive impairment, he made up his mind to do whatever he needed to do to maintain his abilities. Consequently, Respondent adopted a management routine that included waking up early in the morning, walking uphill for approximately five miles, eating breakfast, going to the gym for weight lifting, and then visiting Dr. Barrus' office for one to two hours to undergo memory training. Respondent also takes Vyvanse and vitamins.

73. Dr. Hu made four recommendations: (1) Respondent resume his medical practice in the group setting, under the supervision of Dr. Joshi and other physician colleagues; (2) Respondent continue daily cognitive training and Vyvanse; (3) Respondent undergo neuropsychological evaluations every six months in order to continue monitoring Respondent's cognitive functions; and (4) Respondent continue to undergoing regular follow-up appointments with his psychologist, neurologist, and internist.

#### *Character Testimony*

74. Dr. Chandrashekhar Joshi is a physician licensed since 1973 and specializes in internal medicine and primary urgent care. Dr. Joshi has known Respondent for more than 40 years. Dr. Joshi is the owner of Simi Health Center and employed Respondent in approximately 2009 as a part-time physician. In that capacity, Dr. Joshi has observed Respondent practice medicine and finds Respondent to be very qualified.

75. Dr. Joshi is also Respondent's treating physician and treats him for ADHD and high blood pressure, and prescribes medication to Respondent for both conditions. Dr. Joshi has not been specifically trained in the area of mild cognitive impairment, but has seen Respondent practice and finds him totally competent in how he treats, diagnoses, and prescribes medication to patients. Dr. Joshi has not observed Respondent demonstrating difficulty in remembering the flow in conversations or remembering patient names.

### CONCLUSIONS OF LAW

1. Cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2234, subdivision (d), for incompetence, as set forth in Findings 3 through 43.

#### *The Applicable Law*

2. The standard of proof which must be met to establish the charging allegations herein is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853.) This means the burden rests with Complainant to offer proof that is clear, explicit and unequivocal--so clear as to leave no substantial doubt and sufficiently strong to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

3. The purpose of the Medical Practice Act<sup>2</sup> is to assure the high quality of medical practice; in other words, to keep unqualified and undesirable persons and those guilty of unprofessional conduct out of the medical profession. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App. 3d 564, 574.) The imposition of license discipline does not depend on whether patients were injured by unprofessional

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<sup>2</sup> Business and Professions Code sections 2000 through 2521.

medical practices. (See, *Bryce v. Board of Medical Quality Assurance* (1986) 184 Cal.App.3d 1471; *Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.) Our courts have long held that the purpose of physician discipline by the Board is not penal but to “protect the life, health and welfare of the people at large and to set up a plan whereby those who practice medicine will have the qualifications which will prevent, as far as possible, the evils which could result from ignorance or incompetency or a lack of honesty and integrity.” (*Furnish v. Board of Medical Examiners* (1957) 149 Cal.App.2d 326, 331.

4. Business and Professions Code section 2234 states that the Board shall take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct includes (b) gross negligence; (c) repeated negligent acts (two or more negligent acts); (d) incompetence; and (e) the commission of any act involving dishonesty which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

5. The terms “negligent” and “incompetent” are not synonymous. Incompetence has been defined as a “general lack of present ability to perform a given duty as distinguished from inability to perform such duty as a result of mere neglect or omission.” (*Pollak v. Kinder* (1978) 85 Cal.App.3d 833, 837-838.) “[A] licensee may be competent or capable of performing a given duty but negligent in performing that duty.” (*Id.* at p. 838; see also, *James v. Bd. of Dental Examiners* (1985) 172 Cal.App.3d 1096, 1109 [“Incompetence generally is defined as a lack of knowledge or ability in the discharge of professional obligations”].) “Repeated negligent acts” is defined as two or more acts of negligence. (*Zabetian v. Medical Bd.* (2000) 80 Cal.App.4th 462, 468.)

6. California Code of Regulations, title 16, section 1360, states that for the purposes of denial, suspension or revocation of a license, an act shall be considered to be substantially related to the qualifications, functions or duties of a licensee if to a substantial degree it evidences present or potential unfitness to perform the functions authorized by the license in a manner consistent with the public health, safety or welfare. Such acts include violating any provision of the Medical Practice Act.

### *Analysis*

7. Complainant met her burden of establishing, by clear and convincing evidence, that Respondent lacks competence to perform the duties of a physician, by virtue of Respondent’s failure to successfully pass the PACE program. The evidence clearly shows from the credible testimony of Dr. Norcross that Respondent’s performance was substandard in both Phase 1 and Phase 2 of PACE. Specifically, in Phase 1, Respondent’s history and physical exam were unsatisfactory, his chart reviews were unsatisfactory, his score on PRIMUM was in the first quintile, his score on the three written exams was in the first percentile, his behavior was sometimes unprofessional, and his Microcog screening indicated a need for further evaluation.

In that regard, according to the credible testimony of Dr. Perry and the results of the neuropsychological evaluation administered by him, Respondent suffers from mild neurocognitive impairment, constituting concern for Respondent's ability to practice medicine in a manner that poses no potential danger to his patients.

8. In Phase 2, Respondent's performance was deemed unsatisfactory. Specifically, during clinical observations, Respondent was at times disinterested and falling asleep, his clinical judgment and overall clinical competence scores were unsatisfactory in some cases, and Respondent submitted a plagiarized evidence-based medicine project. Given the above factors, Complainant established her burden of demonstrating cause exists to discipline Respondent's certificate.

9. However, the evidence shows that despite the presence of mild neurocognitive impairment and cortical atrophy, Respondent is able to safely practice at this time. Specifically, Dr. Hu, who completed the independent medical evaluation, as well as Dr. Barras and Dr. Kowell, individually opined that Respondent can practice safely at this time, based on the results of his neurocognitive and neurological testing. In fact, Dr. Hu and Dr. Barras made similar recommendations to ensure Respondent's ability to practice medicine safely: (1) Respondent resume his medical practice in the group setting, under the supervision of Dr. Joshi and other physician colleagues; (2) Respondent continue daily cognitive training and Vyvanse; (3) Respondent undergo neuropsychological evaluations every six months in order to continue monitoring Respondent cognitive functions; and (4) Respondent continue to go to regular follow-up appointments with his psychologist, neurologist, and internist. Given these factors, the public will be adequately protected by the imposition of a period of probation that includes conditions similar to the ones recommended by Dr. Barras and Dr. Hu.

## ORDER

Certificate No. A26513 issued to Respondent, Felix Louis Negrón, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for five years, upon the following terms and conditions:

### **1. Neuropsychological and Neurological Evaluations and Treatment**

Within 30 calendar days of the effective date of this Decision, and every six months thereafter, Respondent shall undergo neuropsychological and neurological evaluations by a Board-appointed clinical neuropsychologist and a Board-appointed neurologist, respectfully, who shall consider any information provided by the Board or designee and any other information the evaluating physician deems relevant and shall furnish a medical report to the Board or its designee. Respondent shall provide the evaluating neuropsychologist and neurologist any information and documentation that the evaluating neuropsychologist and neurologist may deem pertinent.

Following the evaluation, Respondent shall comply with all restrictions or conditions recommended by the evaluating neuropsychologist and neurologist, including the continued consumption of prescribed stimulants and the daily engagement in memory training, within 15 calendar days after being notified by the Board or its designee. If Respondent is required by the Board or its designee to undergo medical treatment (neuropsychological, neurological, or otherwise), Respondent shall within 30 calendar days of the requirement notice, submit to the Board or its designee for prior approval the name and qualifications of a California licensed treating physician(s) of Respondent's choice. Upon approval of the treating physician(s), Respondent shall within 15 calendar days undertake medical treatment and shall continue such treatment until further notice from the Board or its designee.

The treating physician(s) shall consider any information provided by the Board or its designee or any other information the treating physician(s) may deem pertinent prior to commencement of treatment. Respondent shall have the treating physician(s) submit quarterly reports to the Board or its designee indicating whether or not the Respondent is capable of practicing medicine safely. Respondent shall provide the Board or its designee with any and all medical records pertaining to treatment, the Board or its designee deems necessary.

If, prior to the completion of probation, Respondent is found to be physically incapable of resuming the practice of medicine without restrictions, the Board shall retain continuing jurisdiction over Respondent's license and the period of probation shall be extended until the Board determines that Respondent is physically capable of resuming the practice of medicine without restrictions. Respondent shall pay the cost of the neuropsychological and neurological evaluation(s) and treatment.

## **2. Solo Practice Prohibition**

Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: (1) Respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or (2) Respondent is the sole physician practitioner at that location. Respondent must practice in a group setting that will subject Respondent's work to daily review by his peer(s) as part of a quality assurance peer review process.

If Respondent fails to establish a practice with another physician(s) or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, the Respondent's practice setting changes and the Respondent is no longer practicing in a setting in compliance with this Decision, the Respondent shall notify the Board or its designee within five calendar days of the practice setting change. If Respondent fails to establish a practice with another physician(s) or secure

employment in an appropriate practice setting within 60 calendar days of the practice setting change, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established.

### **3. Notification**

Within seven days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change in hospitals, other facilities, or insurance carrier.

### **4. Supervision of Physician Assistants and Advanced Practice Nurses**

During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

### **5. Obey All Laws**

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

### **6. Quarterly Declarations**

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

### **7. General Probation Requirements**

#### *Compliance with Probation Unit*

Respondent shall comply with the Board's probation unit.

#### *Address Changes*

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under

no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

*Place of Practice*

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

*License Renewal*

Respondent shall maintain a current and renewed California physician's and surgeon's license.

*Travel or Residence Outside California*

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

**8. Interview with the Board or its Designee**

Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

**9. Non-practice While on Probation**

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Board's

Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California, will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

#### **10. Completion of Probation**

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

#### **11. Violation of Probation**

Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

#### **12. License Surrender**

Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

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### **13. Probation Monitoring Costs**

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

DATE: March 8, 2017

DocuSigned by:

*Carla L. Garrett*

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CARLA L. GARRETT  
Administrative Law Judge  
Office of Administrative Hearings

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FILED  
STATE OF CALIFORNIA  
MEDICAL BOARD OF CALIFORNIA  
SACRAMENTO April 29 2016  
BY H. Voong ANALYST

8 **BEFORE THE**  
9 **MEDICAL BOARD OF CALIFORNIA**  
10 **DEPARTMENT OF CONSUMER AFFAIRS**  
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 800-2016-020748

13 Felix Louis Negron, M.D.  
14 1350 E. Los Angeles Avenue  
15 Simi Valley, CA 93065

**A C C U S A T I O N**

16 Physician's and Surgeon's Certificate  
17 No. A26513,

Respondent.

18 Complainant alleges:

19 **PARTIES**

20 1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official  
21 capacity as the Executive Director of the Medical Board of California, Department of Consumer  
22 Affairs (Board).

23 2. On or about February 11, 1975, the Medical Board issued Physician's and Surgeon's  
24 Certificate Number A26513 to Felix Louis Negron, M.D. (Respondent). The Physician's and  
25 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought  
26 herein and will expire on November 30, 2016, unless renewed. On April 7, 2016, Respondent's  
27 license was suspended pursuant to a Petition for Interim Suspension Order.  
28

## JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

1 “(g) The practice of medicine from this state into another state or country without meeting  
2 the legal requirements of that state or country for the practice of medicine. Section 2314 shall not  
3 apply to this subdivision. This subdivision shall become operative upon the implementation of the  
4 proposed registration program described in Section 2052.5.

5 “(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and  
6 participate in an interview by the board. This subdivision shall only apply to a certificate holder  
7 who is the subject of an investigation by the board.”

### 8 CAUSE FOR DISCIPLINE

#### 9 **(Incompetence)**

10 6. Respondent Felix Louis Negron, M.D. is subject to disciplinary action under Code  
11 section 2234, subdivision (d), in that he failed the Physician Assessment and Clinical Education  
12 (“PACE”) Program at the University of California San Diego. His performance was substandard  
13 and consistent with a fail, which signifies that he is not competent to practice psychiatry and  
14 poses a potential danger to his patients. The circumstances are as follows:

15 7. In a disciplinary action entitled *In the Matter of the Accusation Against Felix Louis*  
16 *Negron, M.D.*, Case No. 05-2011-217285, Complainant alleged gross negligence and repeated  
17 negligent acts in the care and treatment of a patient. Briefly, Respondent was treating a patient  
18 with antibiotics for several months but he had no clinical grounds upon which to make the  
19 diagnosis. In addition, Respondent destroyed all of the patient’s medical records.

20 8. The Board issued a decision effective November 14, 2014, in which Respondent’s  
21 certificate was subject to a public reprimand, with the conditions that he successfully complete  
22 the Medical Record keeping course and the Physician Assessment and Clinical Education  
23 Program (“PACE”), at the University of California, San Diego.

24 9. On February 3 and 4, 2015, Respondent participated in Phase I of the PACE Program.  
25 He completed a neuropsychological evaluation on May 11, 2015. From June 22 thru 26, 2015,  
26 Respondent participated in Phase II of the PACE Program.

10. Respondent's overall performance in PACE was that of a "fail" which signified a poor performance that was not compatible with overall physician competency and safe practice, representing a potential danger to his patients.

11. The Phase I assessment was deeply concerning and unsatisfactory. During Phase I, Dr. S. performed a one hour oral clinical examination of Respondent. His score of a 4.7 signified average to low average performance. Dr. S. reviewed seven charts, he found two to be unsatisfactory, two were borderline and three were satisfactory.

12. Respondent's clinical decision making and patient management skills were tested through a computerized program called PRIMUM. He scored in the lowest quintile on all eight cases. Part of Phase I includes three written multiple choice exams. On the Ethics and communication portion, Respondent scored 59% which was in the first (lowest) percentile. On the Mechanisms of Disease test, he scored 47%; again, this was in the lowest rank. On the Family Medicine Clinical Science Subject exam, he scored 49 which placed him in the lowest ranking.

13. Respondent's performance during Phase II was also unsatisfactory. His clinical judgment was called into question. During the neuropsychological evaluation, it was discovered that Respondent demonstrated deficits in fine motor skills, and impairment in aspects of executive functions. Problem solving showed impairment, as well as measures of attention, processing speed and learning and memory. Respondent's poor cognitive performance lead the PACE faculty to believe he may have a mild neurocognitive disorder. In both Phase I and II, Respondent received a score of a "fail" which signifies a poor performance that is not compatible with overall physician competency and safe practice.

## DISCIPLINARY CONSIDERATIONS

14. To determine the degree of discipline, if any, to be imposed on Respondent Felix Louis Negron, M.D., Complainant alleges that on or about November 14, 2014, in a prior disciplinary action entitled *In the Matter of the Accusation Against Felix Louis Negron, M.D.* before the Medical Board of California, in Case Number 05-2011-217285, Respondent agreed to

1 a Public Reprimand, in addition to completing PACE courses. That decision is now final and is  
2 incorporated by reference as if fully set forth herein.

3 **PRAYER**

4 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,  
5 and that following the hearing, the Medical Board of California issue a decision:

6 1. Revoking or suspending Physician's and Surgeon's Certificate Number A26513,  
7 issued to Felix Louis Negron, M.D.;

8 2. Revoking, suspending or denying approval of Felix Louis Negron, M.D.'s authority to  
9 supervise physician assistants, pursuant to section 3527 of the Code;

10 3. Ordering Felix Louis Negron, M.D., if placed on probation, to pay the Board the costs  
11 of probation monitoring; and

12 4. Taking such other and further action as deemed necessary and proper.

13  
14 DATED: April 29, 2016



15 for KIMBERLY KIRCHMEYER  
16 Executive Director  
17 Medical Board of California  
18 Department of Consumer Affairs  
19 State of California  
20 Complainant

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